STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155665		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/04/2011		
	PROVIDER OR SUPPLIER		p. wiiv	STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
JEMNING	GS HEALTHCARE (DENTER		NORTE	ł VERNON, IN47265		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0000	and State Lice visit included to Complaints IN IN00085078 a Complaint IN0 Substantiated, related to the a Complaint IN0 Substantiated, deficiencies re allegations are Complaint nur Substantiated, to the allegation	nd IN00086453. 00084545 - No deficiencies allegations are cited. 00085078 - Federal/State elated to the cited at F315. mber IN00086453 - No findings related ons. February 28, March 2011 er: 010996 oer: 155665 200232210	F00	00			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QFU711

Facility ID:

010996

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155665		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/04/2011	
	PROVIDER OR SUPPLIER		701 HE	ADDRESS, CITY, STATE, ZIP CODE NRY ST I VERNON, IN47265	I	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	Diana Siddell, Sharon White 28, March 1, 2 Census bed ty SNF/NF: 87 Total: 87 Census payor Medicare: 8 Medicaid: 74 Other: 5 Total: 87 Sample: 18 Supplemental These deficier findings cited 410 IAC 16.2	RN man, RN (February 2, and 3, 2011) pe: type: sample: 4 ncies also reflect state in accordance with				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155665		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED 03/04/2011			
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
	SS HEALTHCARE C		NORTH	I VERNON, IN47265	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLE	
		155665	B. WIN			03/04/20	11
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
IENNING	SS HEALTHCARE C	PENTED		l	NRY ST I VERNON, IN47265		
					· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	DATE
F0223		view and record	F02		I		04/03/2011
SS=D	review, the fac	cility failed to ensure			It is the policy of this facility to comply with regulatory		
	•	s reviewed for abuse			requirements to protect our		
	were free from	verbal and physical			residents from verbal, mental,		
		ff member in total			sexual, and physical abuse, corporal punishment and		
		(Resident #24)			involuntary seclusion.		
	sample of 16.	(IXOSIGOIII $\pi 2 + j$			Resident #24 suffered no		
	D: 1: : 1	1			negative outcomes from the incident of 1/5/11. Resident #:	24	
	Findings inclu	de:			was monitored by Social Servi		
					for any untoward reactions and	d	
	Resident #24's	clinical record was			none were noted. CNA #10 wa		
	reviewed on 3-	-1-11 at 1:55 p.m.			suspended immediately and a investigation was completed a		
		included, but were			disciplinary actions have been		
	_	multi-farct (sic)			acted upon CNA #7 was		
		trokes) dementia,			counseled and disciplinary act has been acted on.	ion	
	` •				Facility DON/SSD has conduc	ted	
		k pain, degenerative			resident interviews with reside		
		ype 2 diabetes,			who are alert and oriented and	i	
	depression and	l cellulitis. His most			interview able regarding staff interactions and any concerns	of	
	recent Minimu	ım Data Set (MDS)			abuse related items . Non wer		
	assessment, da	ited 1-29-11,			noted		
	, and the second se	long term and short			On 1/7/2011 the SSD		
	term memory	· ·			re-educated staff on types of abuse and reporting alleged		
		•			abuse in a timely manor. On		
	_	all 3 words after 5			3/18/2011 an all staff meeting		
		n inability to identify			was conducted to review the requirements for reporting alle	and	
	the current day	of the week, the			abuse in a timely manor .The	geu	
	current month	or year. The MDS			DON or designee will conduct		
	did not identify	y any mood or			random interviews of 5-10 staf	f	
		ies directed at other			members 2 times/week for 3 months to assess their		
	persons.	Description we control			knowledge of the abuse policy		
	persons.				and procedure especially in		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPL	
711.12.11.11	or condition	155665	A. BUII B. WIN			03/04/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER				NRY ST		
JENNING	GS HEALTHCARE C	CENTER		NORTH	H VERNON, IN47265		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	The facility ad a copy of a dod "Fax/Incident 4:30 p.m. This CNA #7 contar phone on 1-6-10:30 a.m. to rewhich occurred 1-5-11 at 6:15 indicated CNA with CNA #10 morning care to indicated Resident anger at Resident #24 in going to hit med #10 indicated, bending my fir report indicated proversident. It fur #10 stated to Copresence of Resident #24 in the presence of Resident #24 in the presence of Resident.	ministrator provided cument entitled, Report" on 3-3-11 at a document indicated cted the facility by 11 at approximately report an incident d the previous day, a.m. The report A #7 was working in providing to Resident #24. It dent #24 became bent back the fingers It indicated CNA #10 d shook her fist in ent #24. It indicated ndicated, "You're not e," to which CNA "I am if you keep ngers back." The d the staff members yiding care to the other ther indicated CNA			regards to reporting abuse in a timely manner. SSD or design will interview residents during quarterly care conference for a concerns related to staff interactions or abuse. Results of these interviews will reported to the facility RM/QACommittee by the DON less than monthly for review a recommendations. 4/3/2011	ee any I be N no	

l	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPL	
		155665	B. WIN			03/04/2	.011
NAME OF I	PROVIDER OR SUPPLIER	3		1	ADDRESS, CITY, STATE, ZIP CODE		
JENNING	GS HEALTHCARE (CENTER		1	NRY ST I VERNON, IN47265		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	\	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
TAG	him."	LESC IDENTIF TING INFORMATION)		IAG			DATE
	111111.						
	In an interviev	w with CNA #7 on					
		0 p.m., she indicated					
	the thought of	having to report her					
	_	ght lose her job as a					
	result of the re	eport was why she					
	delayed report	ting the incident. She					
	indicated she l	kept thinking about it					
	and could not sleep that night						
	"because it is	my job to protect the					
	residents." Sh	ne indicated she called					
	and reported the	he incident the					
	following mor	rning [to the facility.]					
		she was placed on a					
		and inserviced on					
		orting. She indicated					
	the other empl						
	1	the same topics on					
	1-7-11.	1					
	The report ind	licated that upon					
	1 *	report of this abuse,					
	1	spended CNA #10					
	1	tigation and was					
	ı * •	1-7-11. The report					
		A #7 was provided 1					
	on 1 inservice	_					

PRINTED: 03/24/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155665		(X2) MULTIPLE CO A. BUILDING B. WING	INSTRUCTION	(X3) DATE SURVEY COMPLETED 03/04/2011		
	PROVIDER OR SUPPLIER		STREET A	NRY ST VERNON, IN47265		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	reporting abus indicated all stone the same to report and soc documentation #24 was monituntoward react noted. The repfacility notified Department of the same date,	n indicated Resident				

010996

	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	JLTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155665	A. BUII			03/04/2011
		10000	B. WIN		ADDRESS STEW STATE ZID CODE	00/04/2011
NAME OF F	PROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE	
JENNING	GS HEALTHCARE C	CENTER	701 HENRY ST NORTH VERNON, IN47265			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
F0225		view and record	F02		Please accept this official notice	
			1.02	23	of dispute in regards to the	04/03/2011
SS=D	*	eility failed to ensure			attached F225 Tag from our	
	_	an allegation of abuse			recent annual survey from 2/28/2011 to 3/4/2011.It is the	
	timely for 1 of	2 residents			policy of this facility to comply	
	reviewed for a	abuse in a sample of			with regulatory requirements to	
	18. (Resident	#24)			protect our residents from vert	oal,
	•	,			mental, sexual, and physical abuse, corporal punishment ar	nd
	Findings inclu	de·			involuntary seclusion.	
	i mamgs mera	ac.			Resident #24 suffered no	
	Resident #24's clinical record was				negative outcomes from the incident of 1/5/11. Resident #2	24
					was monitored by Social Servi	
		-1-11 at 1:55 p.m.			for any untoward reactions and	d
	His diagnoses	included, but were			none were noted. CNA #10 wa	
	not limited to	multi-farct (sic)			suspended immediately and a investigation was completed a	
	(many small st	crokes) dementia,			disciplinary actions have been	
	weakness, bac	k pain, degenerative			acted upon CNA #7 was	.
	ŕ	ype 2 diabetes,			counseled and disciplinary act has been acted on.	ion
		l cellulitis. His most			Facility DON/SSD has conduct	ted
	•				resident interviews with reside	l I
		m Data Set (MDS)			who are alert and oriented and interview able regarding staff	1
	assessment, da	· · · · · · · · · · · · · · · · · · ·			interactions and any concerns	of
	indicated both	long term and short			abuse related items . Non were	
	term memory j	problems with			noted	
	inability to rec	all 3 words after 5			On 1/7/2011 the SSD re-educated staff on types of	
	minutes and ar	n inability to identify			abuse and reporting alleged	
		of the week, the			abuse in a timely manor. On	
	_	or year. The MDS			3/18/2011 an all staff meeting was conducted to review the	
	did not identify				requirements for reporting alle	ged
	·	·			abuse in a timely manor .The	
		ies directed at other			DON or designee will conduct	
	persons.				random interviews of 5-10 staf members 2 times/week for 3	'

AND PLAN OF CORRECTION IDENTIFICATION NUME	BER:	ILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
155665	B. WI			03/04/2011
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	•	701 HEI	ADDRESS, CITY, STATE, ZIP CODE NRY ST VERNON, IN47265	
(X4) ID SUMMARY STATEMENT OF DEFICIEN PREFIX (EACH DEFICIENCY MUST BE PERCEDED TAG REGULATORY OR LSC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
The facility administrator prova copy of a document entitled, "Fax/Incident Report" on 3-3-4:30 p.m. This document indi CNA #7 contacted the facility phone on 1-6-11 at approxima 10:30 a.m. to report an incider which occurred the previous d 1-5-11 at 6:15 a.m. The report indicated CNA #7 was workin with CNA #10 in providing morning care to Resident #24. indicated Resident #24 became combative and bent back the fof CNA #10. It indicated CNA then raised and shook her first anger at Resident #24. It indicated, "You've going to hit me," to which CNA #10 indicated, "I am if you kee bending my fingers back." The report indicated the staff mem continued providing care to the resident. It further indicated CHA #10 stated to CNA #7 in the presence of Resident #24, "I disee how anyone can like him;	ately ately ately ately ately ately ately ately ately atel atel at a single atel atel atel atel atel atel atel at		months to assess their knowledge of the abuse policy and procedure especially in regards to reporting abuse in a timely manner. SSD or design will interview residents during quarterly care conference for a concerns related to staff interactions or abuse. Results of these interviews will reported to the facility RM/QACommittee by the DON less than monthly for review as recommendations. 4/3/2011	a ee any I be

l	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLETED 03/04/2011	
		155665	B. WIN			03/04/2	011
NAME OF I	PROVIDER OR SUPPLIER	1		701 HEI	ADDRESS, CITY, STATE, ZIP CODE		
JENNING	GS HEALTHCARE (CENTER		1	I VERNON, IN47265		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
1.10	him."			1110			BIIID
	111111.						
	In an interviev	w with CNA #7 on					
	3-3-11 at 12:30 p.m., she indicated						
	the thought of	having to report her					
	friend who mi	ght lose her job as a					
	result of the re	eport was why she					
	delayed not re	porting the incident.					
	She indicated she kept thinking						
	about it and could not sleep that						
	night "because	e it is my job to					
	protect the res	idents." She					
	1 ^	called and reported					
		e following morning					
		.] She indicated she					
	-	a coaching plan and					
	_	abuse and reporting.					
		the other employees					
		ed on the same topics					
	on 1-7-11.	d on the same topics					
	011 1-/-11.						
	The report ind	icated that upon					
		report of this abuse,					
		spended CNA #10					
		•					
	^	tigation and was					
		1-7-11. The report					
		A #7 was provided 1					
	on 1 inservice	education on					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/04/2011	
	PROVIDER OR SUPPLIER		STREET A 701 HE	ADDRESS, CITY, STATE, ZIP CODE NRY ST I VERNON, IN47265			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE	
	reporting abus indicated all stone the same to report and soc documentation #24 was monituntoward react noted. The repfacility notified Department of the same date,	n indicated Resident					

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPLETED	
		155665	B. WING			03/04/20	011
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					NRY ST		
JENNING	SS HEALTHCARE (CENTER		NORTH	H VERNON, IN47265		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX CR		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
F0226		view and record	F02		Please accept this official notice	re l	04/03/2011
			1.02.	20	of dispute in regards to the	~	04/03/2011
SS=D	*	cility failed to ensure			attached F-226 Tag from our		
		facility policy for			recent annual survey from 2/28/2011 to 3/4/2011.		
	reporting an al	legation of abuse			It is the policy of this facility to		
	timely for 1 of	2 residents			comply with regulatory		
	· ·	abuse in a sample of			requirements to protect our		
	18. (Resident	•			residents from verbal, mental, sexual, and physical abuse,		
		– 3)			corporal punishment and		
	Findings include:				involuntary seclusion.		
					Resident #24 suffered no negative outcomes from the		
					incident of 1/5/11. Resident #	24	
		clinical record was			was monitiored by Social		
	reviewed on 3.	-1-11 at 1:55 p.m.			Services for any untoward		
	His diagnoses	included, but were			reactions and non were noted. CNA #10 was suspended		
	not limited to	multi-farct (sic)			immediately and an investgation	on	
		trokes) dementia,			was completed and diciplinary		
	` •	k pain, degenerative			actions have been acted upon CNA #7 was counseled and		
		ype 2 diabetes,			disciplinary action have been		
	-				acted on.		
	-	l cellulitis. His most			Facility DON/SSD has conduc		
		ım Data Set (MDS)			resident interviews with reside who are alert and oriented and		
	assessment, da	ited 1-29-11,			interviewable regarding staff		
	indicated both	long term and short			interactions and any concerns		
	term memory	problems with			abuse realted items . Non wer noted	e	
	inability to rec	eall 3 words after 5			On 1/7/2011 the SSD		
	-	n inability to identify			re-educated staff on types of		
		of the week, the			abuse and reporting alledged		
	_				abuse in a timley mannor. On 3/18/2011 an all staff meeting		
		or year. The MDS			was conducted to review the		
	did not identify	-			requirements for reporting		
	behavioral issu	ues directed at other			alledged abuse in a timley mannor .The DON or designed	<u>,</u>	
						´	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
THETETAL	or conduction	155665	- 1	LDING		03/04/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	NRY ST		
JENNING	GS HEALTHCARE C	CENTER		NORTH	l VERNON, IN47265		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
PREFIX	persons. The facility ad a copy of a dod "Fax/Incident 4:30 p.m. This CNA #7 conta phone on 1-6-10:30 a.m. to r which occurred 1-5-11 at 6:15 indicated CNA with CNA #10 morning care to indicated Resident #24 in going to hit med #10 indicated, bending my fir report indicated.	Iministrator provided cument entitled, Report" on 3-3-11 at s document indicated cted the facility by 11 at approximately report an incident d the previous day, a.m. The report A #7 was working in providing to Resident #24. It dent #24 became bent back the fingers It indicated CNA #10 d shook her fist in ent #24. It indicated ndicated, "You're not e," to which CNA "I am if you keep ngers back." The dd the staff members		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION DATE s of eek a ee any li be	
		viding care to the rther indicated CNA					
	#10 stated to C						
	presence of Re	esident #24, "I don't					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155665			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/04/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN47265					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE		
	see how anyor him."	ne can like him; I hate						
	3-3-11 at 12:3 the thought of friend who mi result of the re delayed not re She indicated about it and co night "because protect the res indicated she of the incident th [to the facility was placed on inserviced on She indicated were inservice on 1-7-11. The report ind receiving the re the facility sus pending invest terminated on	w with CNA #7 on 0 p.m., she indicated having to report her ght lose her job as a eport was why she porting the incident she kept thinking ould not sleep that e it is my job to idents." She called and reported e following morning a coaching plan and abuse and reporting. The other employees ed on the same topics icated that upon report of this abuse, spended Staff #10 tigation and was 1-7-11. The report of #7 was provided 1						

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/04/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN47265					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE	(X5) COMPLETION DATE		
	reporting abus indicated all stone the same to report and soc documentation #24 was monituntoward react noted. The repfacility notified Department of the same date,	e and timeliness of e. The report further taff were inserviced spics on 1-7-11. The ial services in indicated Resident						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	ETED
		155665	B. WING			03/04/2	011
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				NRY ST		
JENNING	SS HEALTHCARE (CENTER			I VERNON, IN47265		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0279	Based on record	review and interview, the	F02	79	It is the policy of this facility to		04/03/2011
SS=D	facility failed to	plan care to address			comply with regulatory requirements regarding the		
-	residents' needs 1	related to moods, eating,			development and implementat	ion	
	pressure ulcers, a	and falls and failed to			of the comprehensive care pla		
	•	planned to meet residents'			Resident #A's comprehensive		
		identified in residents'			care plan has been revised to		
	_	deficient practice			include care plans for		
		1			hygiene/bathing, mood, eating	,	
		residents in a sample of			pressure ulcers, and falls.		
		comprehensive care plan			Resident #38's comprehensive	9	
	development. (R	Residents #A and #38)			care plan has been revised to include care plans for		
					communication problems, ADL	_S	
	Findings include				(including bathing/hygiene,		
					toileting, and transferring)		
	A policy and pro	cedure for			A comprehensive QA of each		
		" with a revised date of			resident's care plans is being		
		ed by the Administrator			conducted to identify care		
	_	-			plans for moods, falls, pressur		
		5 p.m. The policy			ulcers and eating/ADLs. Identi issues will be corrected as the		
	indicated, but wa				is being completed.	QΛ	
		staff documents the			The IDT has been re eductate	d	
	provision of nurs	sing care according to			on the regulatory requiremnts		
	nursing standard	s and regulatory			regarding development and		
	requirements. D	ocumentation tools are			implementation of comprehens		
	designed, when d				care plans. A comprehensive (
	,	clinical care provided to			of each resident's care plans is		
		ent and to ensure the			being conducted to identify iss based on the CAA's(care	uco	
	_	mation is available to all			assessment areas) and other		
					nursing assessments. Care pla	ans	
		team members regarding			for deficit areas will be develop		
		entions and responses.			and implemented over the nex		
		rsing documentation is			90 days as quarterly MDS's co	me	
	based on residen	t/patient clinical status,			up for review. The DON or		
	clinical need and	regulatory requirements.			designee will QA the clinical record of 4-5 new admission,		
	Components of t	he nursing			annual and/or SCOC MDS CA	A's	
		rocess included, but were			and other nursing assessment		
		,			•		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155665		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/04/2011	
	PROVIDER OR SUPPLIER		B. WING	STREET A	ADDRESS, CITY, STATE, ZIP CODE NRY ST I VERNON, IN47265	00/01/2	
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIEN REGULATORY OR not limited to, the	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) tools each week for 3 months insure appropriate care plans	to	(X5) COMPLETION DATE
	through the care documentation is admission. After admission, nursing with the interdiscent evaluate the residual eveloping the control of the care. The interdist to observe and eversident/patient to comprehensive comprehensiv	f resident/patient terviews and goals plan processAdmission initiated upon the first day of ng staff continues to work ciplinary team to further dent/patient and assist in comprehensive plan of sciplinary team continues valuate the o complete the first are plan" record was reviewed on .m. The record indicated admitted with diagnoses t were not limited to, y, cerebral vascular etes mellitus.			insure appropriate care plans being developed and implemented in a timely mann. The results of these QA will I reported by the DON to the fa RM/QA Committee no less that monthly for review and recommendations. 4/3/2011	er. oe cility	
	limited assistance no falls, and had healed pressure t	teraction, required e of one for eating, had no pressure ulcers or elcers.					

010996

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
1111212111	or continue from	155665	A. BUI			03/04/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	NRY ST		
	SS HEALTHCARE (NORTH	I VERNON, IN47265		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		nt #A had a total mood	+	IAG	,		DATE
		ating a high frequency of					
	· ·	limited assistance of one					
		fall within the last two to					
	_	indicated the resident was					
	-	oing pressure ulcers but					
	-	inhealed pressure ulcer.					
	The significant c	hange MDS dated					
	_	the following areas					
		re plan to address					
		ood, eating, pressure					
	ulcers, and falls.	, 0,1					
	The care plan fai	led to include mood,					
	eating, hygiene/b	pathing, pressure ulcers					
	and falls as probl	lem/issues with goals and					
	approaches.						
		2/2/11					
		iew on 3/3/11 at 4:24					
	•	r of Nursing indicated					
		orative walking care plan					
		and indicated this					
		nave a care plan for the					
	other areas.						
	During an intervi	iew on 3/4/11 at 1:30					
	_	r of Nurses indicated the					
	-	state guidelines for care					
	plan developmen	_					
	pran ac veropinen						
	l						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155665	B. WIN			03/04/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			l	NRY ST		
JENNING	SS HEALTHCARE (CENTER		l	I VERNON, IN47265		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	 	TAG	DEFICIENCY)		DATE
F0279		s clinical record was	F02	79	It is the policy of this facility to		04/03/2011
SS=D	reviewed on 3-1-	11 at 9:40 a.m. His			comply with regulatory requirements regarding the		
	diagnoses includ	ed, but were not limited			development and implementat	ion	
	to, closed head in	njury as a result of a			of the comprehensive care pla		
		cident, left hemiparesis,			Resident #A's comprehensive		
		to speak or talk),			care plan has been revised to		
		presenile dementia,			include care plans for		
	-	-			hygiene/bathing, mood, eating	,	
		ulty in swallowing), and			pressure ulcers, and falls.		
	osteoarthritis.				Resident #38's comprehensive care plan has been revised to)	
					include care plans for		
	His most recent l	Minimum Data Set			communication problems, ADI	_S	
	(MDS) assessme	nt, dated 2-4-11,			(including bathing/hygiene,		
	indicated modera	ately impaired abilities to			toileting, and transferring)		
	make decisions r	egarding day to day			A comprehensive QA of each		
		IDS assessment indicated			resident's care plans is being		
		nsive assistance of 2 or			conducted to identify care		
	-				plans for moods, falls, pressur ulcers and eating/ADLs. Identi		
	•	transferring from one			issues will be corrected as the		
		er, such as from bed to			is being completed.	Φ.	
	wheelchair. This				The IDT has been re eductate	d	
	indicated Reside	nt #38 required total			on the regulatory requiremnts		
	dependence on a	nother person for			regarding development and		
	dressing, bathing	and general hygiene			implementation of comprehens		
	issues. It indicat	ed he required extensive			care plans. A comprehensive		
		ersons with toileting. It			of each resident's care plans is being conducted to identify iss		
	•	able to feed himself with			based on the CAA's(care	ues	
		e of 1 person. The MDS			assessment areas) and other		
		•			nursing assessments. Care pla	ans	
		ated he has no speech			for deficit areas will be develop		
	-	ne is rarely or never			and implemented over the nex		
		n which he rarely or			90 days as quarterly MDS's co	me	
	never understand	ls what is said. The MDS			up for review. The DON or		
	assessment sumn	nary, dated 11-22-10,			designee will QA the clinical record of 4-5 new admission,		
	indicated care pla	an triggered areas to			annual and/or SCOC MDS CA	A's	
	-	ication. Resident #38's			and other nursing assessment		
					!		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QFU711 Facility ID: 010996

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI	(X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN	OF CORRECTION	155665	A. BUILD			COMPL 03/04/2	
		10000	B. WING		DDDEGG CITY GTATE ZID CODE	00/04/2	<u> </u>
NAME OF F	PROVIDER OR SUPPLIER			701 HEI	ADDRESS, CITY, STATE, ZIP CODE		
JENNING	GS HEALTHCARE (CENTER			VERNON, IN47265		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION DATE
TAG				TAG	tools each week for 3 months	to	DATE
	1 *	are did not include issues			insure appropriate care plans		
	~ ~	nmunication problems, es of daily living, such as			being developed and		
		transferring, or toileting.			implemented in a timely manner		
	danning, nygiche	transferring, or toffetting.			The results of these QA will be reported by the DON to the face		
	In interview with	the DON on 3-1-11 at			RM/QA Committee no less that		
		ndicated she could not			monthly for review and		
	·	lans for Resident #38			recommendations. 4/3/2011		
		(activities of daily living			7/0/2011		
	" "	bathing and toileting),					
	communication of	C					
		of a document entitled					
	1	are" for use by the CNA's					
	1 -	g assistants) which					
	`	some of the residents on					
	the same hall as I	Resident #38. Resident					
	#38's "Daily Plar	of Care" entry included					
	information rega	rding his level of urinary					
	and bowel contin	ency, that he was to					
	receive a mechan	nical soft diet with nectar					
	thick liquids and	the need to remain up for					
	1 hour after meal	s in a 90 degree position,					
	_	1 to 2 persons to assist					
		for any transfers, to					
		while he is on the toilet,					
		nmunication board that he					
	· ·	o use the communication					
	1	g to talk with him. She					
	indicated this do						
	permanent part o	f the resident's record.					
	3.1-35(a)						
	3.1-35(b)(1)						

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155665	A. BUILDING		COMPLETED 03/04/2011	
		155005	B. WING		03/04/2011	
NAME OF F	PROVIDER OR SUPPLIER	1		ADDRESS, CITY, STATE, ZIP CODE		
	GS HEALTHCARE (NORTH	:NRY ST H VERNON, IN47265		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE	
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCE)	DATE	
					-	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155665		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/04/2011		
JENNING	PROVIDER OR SUPPLIER	ENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN47265				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0315 SS=D	and record reversal failed to ensure supplies were timely changed catheter and direction whose functioning prodeficient practive residents review urinary catheter 18. (Resident Tindings inclusive 1. On 02/28/1 Resident #D was awake and to be urinary drainage side of the residents review of the residents review of Legislation 2:28 p.m. indicates the product of the residents of the residents review of Legislation 2:28 p.m. indicates the product of the residents review of Legislation 2:28 p.m. indicates	available to provide sof the urinary rainage bag for a urinary tract se catheter was not operly. This ice affected 1 of 7 wed related to ers in the sample of #D) de: 1 at 11:25 p.m., vas observed to be be resting in bed. A ge bag attached to the ident's bed was a draining dark amber PN #1 on 02/28/11 at cated the LPN needed inary drainage bag on	F03	15	It is the policy of this facility to comply with regulatory requirements for maintaining adequate supplies to meet the residents' needs. 1. Resident: had no negative outcomes associated with this issue. Resident #D's indwelling cathe and drainage bag have been changed according to the physician's order. All future catheter changes will be completed in a timely manner according to the physician's order.2. Residents with indwell catheters have been assessed appropriate physician ordered changes of catheters and drainage bag. No negative outcomes were identified. 3. A par level for indwelling cathers French and balloon size, drain bags, and insertion kits has be developed. The Central Suppl Clerk will restock the catheter supplies weekly to maintain a level which guarantees an adequate supply to the resident The par level will be adjusted residents are admitted or discharged. DON will re-education licensed staff on facility par level or indwelling catheters and catheter supplies and staff access to central supply 24 hor a day. The DON will monitor the par level weekly for 3 months ensure adequate supplies are being maintained to meet the residents with indwelling catheters. 4. The results of this catheters. 4. The results of this	eter ing d for s by hage heen y par hts. as ate vel our he to	04/03/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPLI	
ANDILAN	or connection	155665	A. BUI			03/04/20	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF I	PROVIDER OR SUPPLIER			1	NRY ST		
JENNING	GS HEALTHCARE (CENTER		NORTH	I VERNON, IN47265	_	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
		/11) and there were			monitoring will be reported to t		
	no drainage ba	ngs available. The			facility RM/QA Committee by t DON no less than monthly for	ne	
	LPN indicated	during the month of			review and		
	January Reside	ent #D's catheter was			recommendations.5.4/3/2011		
		ere was not a catheter					
	_	ded to change the					
	resident's cath						
	indicated the r	esident's catheter did					
	not get change	ed until 3 days later.					
	On 02/28/11 a	t 10:58 p.m. the DON					
	arrived at the f	facility to look for					
	urinary draina	ge bags. After					
	searching thro	ugh supply closets					
	and telephone	texting the person in					
	charge of orde	ring supplies, she					
	determined the	ere were no urinary					
	drainage bags	in the building. She					
	received a tele	phone text message					
	from the suppl	ly clerk which					
	indicated, "The	ere were 2 (drainage)					
	bags today & t	they were used.					
		rrow." The DON					
	indicated staff	had told her there					
	were no draina	age bags "yesterday"					
	(Sunday) and '	"I verbally told					
	(Supply Clerk	#1) that we needed					
	drainage bags.	There were (2) 16					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		COMPL	
		155665	B. WIN	G		03/04/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
IENNING	GS HEALTHCARE (CENTED			NRY ST I VERNON, IN47265		
					VERNON, IN47205		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	French Foley	catheters (common					
	size often used	d catheter) available					
	in the facility	supply of catheters."					
	The DON indi	cated some supplies					
	were kept lock	xed behind the D hall					
	nurse's station	and she and Supply					
	Clerk #1 had a	a key. The DON					
	indicated she a	and the supply clerk					
	took turns bein	ng on call since they					
	both lived nea	r the facility and if					
	staff needed su	upplies which were					
	not readily ava	ailable they could call					
	either the DOI	N or the supply clerk					
	and they woul	d come in and unlock					
	the door.						
	Interview of S	upply Clerk #1 on					
		:15 a.m. indicated					
	there was a lac	ck of drainage bags					
		f 02/28/11. Supply					
	_	ated there was 1					
		on Monday and a					
	_	'busted" and someone					
		emaining drain bag					
		Supply Clerk #1					
	· ·	supply truck came on					
		Irainage bags were					
	replenished.	irumugo ougs wore					
	replemsned.						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE COMPL	
		155665	A. BUII B. WIN			03/04/2	
JAME OF DR	DOVIDED OD SLIDDI IED		D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	ļ.	
	ROVIDER OR SUPPLIER				NRY ST		
JENNINGS	S HEALTHCARE C	CENTER		NORTH	I VERNON, IN47265		
X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	*	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	Review of Res	sident #D's clinical					
	record on 02/2	28/11 at 2:40 p.m.					
I	indicated the fe	•					
		8					
	Resident #D ha	ad diagnoses which					
	included, but v	were not limited to,					
	heart failure, A	Alzheimer type					
	dementia, and	cellulitis.					
	A physician's i	re-write order for					
	February 2011	indicated an order,					
	dated 12/17/10	0, for Foley catheter					
	to bedside drai	inage - may change					
		• •					
	-	ft and as needed.					
	•						
	An "Admission	n/Re-Admission Data					
	Collection & I	Initial Plan of Care,"					
	form, dated 12	2/17/10, indicated the					
	resident was re	e-admitted to the					
	facility on 12/1	17/10 with a Foley					
		pen area on buttocks					
	and lower extr	remities.					
].	A care plan, da	ated 12/20/10,					
	indicated, "Pro	oblems/issues Foley					
	(catheter) (rela	ated to) BPH (benign					
	included, but wheart failure, A dementia, and A physician's refebruary 2011 dated 12/17/10 to bedside drait every month & care every shift An "Admission Collection & If form, dated 12 resident was refacility on 12/10 catheter and open and lower extra A care plan, daindicated, "Pro-	Alzheimer type cellulitis. re-write order for indicated an order, 0, for Foley catheter inage - may change as needed - cath ft and as needed. on/Re-Admission Data initial Plan of Care," 2/17/10, indicated the e-admitted to the 17/10 with a Foley pen area on buttocks remities. ated 12/20/10, oblems/issues Foley					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155665		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/04/2011		
	PROVIDER OR SUPPLIER		B. WINC	STREET A	DDRESS, CITY, STATE, ZIP CODE NRY ST VERNON, IN47265		
JENNING (X4) ID PREFIX TAG	prostatic hypertrophy)(Foley Catheter) care every shift (Change) (every) month & (as needed)" A 5 day admission MDS (Minimum Data Set) assessment, dated 12/23/10, and an MDS, dated 02/04/11, indicated Resident #D was cognitively impaired and was not reliable for interview, the					ΤΕ	(X5) COMPLETION DATE
	resident required extensive assistance of staff for care, and the resident had an indwelling urinary catheter.						
	dated 01/10/11 indicated, "(tract infection) A "Care Track dated 01/11/11 indicated, "((Antibiotic)/(u	Antibiotic/urinary continued" Narrative Note," at 3:15 a.m., Catheter) care done. rinary tract infection) Jrine much clearer					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155665		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/04/2011		
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE NRY ST VERNON, IN47265		
(X4) ID PREFIX	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	A "Care Track dated 01/13/11 indicated, "(Arinfection) (correction) (correction) (correction) (correction) (correction) (correction) urine Urine clear yellow (Antibiotic/urine (continued)((bedside drained) (antibiotic) Ballow (antibiotic) (correction) (correcti	ntibiotic/urinary tract atinued" Narrative Note," (Friday) at 4:00 I, "(Decreased noted to catheter. Illow. nary tract infection) Foley catheter) to age). (Continues) on ctrim & Macrobid ed to treat urinary		TAG	DEFICIENCY)		DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155665		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/04/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN47265				
	SUMMARY S' (EACH DEFICIENT REGULATORY OR leak. (No) (16) Catheters) in state (continue) to reduce (continue) to reduce (continue) to reduce (continue) to reduce (continue) (con	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) French) (Foley tock to replace. Will monitor(7-3 shift) up for meals down toFluids for (urinary tract A Narrative Note" for I shift) indicated,)(continues on c (urinary tract wounds(Resident s) to pull at & play er). (Catheter) care A Narrative Note"for 20 p.m. indicated, rinary tract infection)	701 HE	NRY ST	ON D BE	(X5) COMPLETION DATE	
	(catheter) leak constantly pul & at penis(7 (Foley cathete (amount) uring unable to flush	Catheter) care done & ing. (Resident #D) ling @ cath (catheter) -11 shift) 2:05 p.m. r) leaking (large) e around meatus - n. Cath occluded. ed, much difficulty					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155665		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/04/2011		
NAMEOU	DDOVIDED OF GUIDN TER		B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00.01.2	
	PROVIDER OR SUPPLIER				NRY ST		
(X4) ID	GS HEALTHCARE (FATEMENT OF DEFICIENCIES		ID	I VERNON, IN47265		(V5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	removing cath						
	` 1 1	y) 5 - 10 minutes &					
	able to remove	,					
		ill re-anchor cath					
	when correct s	size Foley					
	obtained"						
	A "Care Track	Narrative Note" for					
		shift) indicated,					
	`	er) placed by RN on					
	duty"						
	Interview of th	ne DON on 03/01/11					
	at 4:22 p.m. in	dicated she did not					
	remember any	one telling her they					
	needed a 16 Fi	rench catheter. The					
	DON indicated	d she phoned the					
	family and wa	s told by the family					
	that Resident #	D's catheter had					
	previously bee	en changed around					
		2/16/10 - shortly					
		dent was re-admitted					
	to the facility.						
	A nolicy titled	"Cothotor Coroll					
		"Catheter Care" was					
	-	the DON on 03/01/11					
	_	The policy indicated,					
	"Catheter Care	e - muwening					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	155665	- 1	LDING		03/04/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
	PROVIDER OR SUPPLIEF			701 HEI	NRY ST		
JENNING	GS HEALTHCARE (CENTER		NORTH	I VERNON, IN47265		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
	(catheter) - Pu	rpose: To provide					
	safe and prope	_					
	resident/patier	nt with an indwelling					
	catheter by ev	aluating elimination					
	1	zing risk of bladder					
		rify physician's order					
	for catheter ca	re and					
	maintenance	.Check catheter					
	system and en	npty drainage bag at					
	least every shi	ftMonitor for					
	catheter comp	lications that may					
	result from, bu	at are not limited to:					
	Obstruction	bladder					
	spasmsLeak	age around					
	catheter"						
	This federal ta	ig is related to					
	Complaint IN	00085078.					
	3.1-41(a)(2)						
	l						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155665			(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED 03/04/2011	
		100000	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/04/2011
NAME OF I	PROVIDER OR SUPPLIER		l l	ENRY ST	
	GS HEALTHCARE (NORTH	l VERNON, IN47265	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155665	B. WING			03/04/2011	
NAME OF D	DOMINED OD GUDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			701 HE	NRY ST		
JENNING	SS HEALTHCARE C	CENTER		NORTH	H VERNON, IN47265		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	F0371		It is the policy of this facility to		DATE
F0371		rvation, interview,	F03	/ 1	comply with regulatory		04/03/2011
SS=F	and record review, the facility				requirements to store prepare		
		e salad dressings			and serve food in a sanitary manor.F-371 Food		
	were discarded	d accorded to policy;			Procure,Store/Prepare/Serve-		
	failed to ensur	e food items were			Sanitary1. No residents were		
	dated when op	ened; failed to ensure			identified. Facility complied with re-filling buckets of warm water		
	sanitation buck	kets were utilized;			with sanitizing solution during		
	and failed to en	nsure kitchen			surveyor rounds in dietary.		
	equipment was	s clean. These			Buckets were available during morning shift and were not yet		
	• •	vere made during 2 of			refilled prior to lunch. The jar o		
		rvations. These			Italian Dressing, Salsa, Thous	and	
					Island Dressing was immediat		
	deficient pract				discarded. The following items were deep cleaned on	5	
	potential to aff	fect 85 of 87 residents			2/28/2011:The gas stove, shell	lf,	
	who eat foods	prepared in the			jars of spices, deep fat fryer,		
	facility's kitch	en.			double convection oven, and t top of the dishwasher. 2. No	he	
					residents were affected. Facili	tv	
	Findings inclu	de:			has conducted a review of die		
		.			opened items to ensure prope	r	
	Duning about	ation town of the			labeling of items. 3. Dietary employees were re-inserviced	on	
	•	ation tour of the			the following	J.,	
		ne Dietary Manager			topics:SanitationSanitation and		
	•	28/11 at 10:55 a.m.			Food ProductionCleaning and Sanitizing / Food and		
	the following of	observations were			DishcartsCleaning and Sanitiz	ing/	
	made during lu	unch preparation.			Counters and Tabletops.Food	-	
	~	ved at 11:15 a.m.			LabelingDietary Service		
					Manager/designee will perforn documented QA walking tours		
	 1 No sanitatio	on buckets were			the kitchen area daily which w		
				include proper utilization of			
	prepared. Interview of the Dietary Manager on 02/28/11 at 11:00 a.m.				sanitation buckets and proper		
					labeling of opened food and following cleaning and sanitati	on	
					J		

010996

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155665		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING			(X3) DATE SURVEY COMPLETED 03/04/2011	
	PROVIDER OR SUPPLIER		B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN47265				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
TAG	indicated the swere emptied at 2. One jar of salad dressing 1/4 full and to the outside of salad dressing 12/04/10 as the been opened. a use by date. 3. One jar of Dressing" was full. This jar of dated when op not have a use 4. One jar of to be 1/4 full. dated when op have a use by 6. One jar of dressing was of full. This jar of marked 12/13/	anitation buckets after breakfast. 'Thousand Island" was observed to be have black spots on the bottle. The jar of was marked e day the bottle had This jar did not have creamy "Italian observed to be 1/4 of dressing was not bened. This jar did by date. 'Salsa" was observed This jar was not bened and did not		TAG	schedules for 3 months. 4. Results of QA rounds will be forwarded to RM/QA for further review and recomendations.5 4/3/2011		DATE

010996

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155665		A. BUILDING	E CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 03/04/2011	
	PROVIDER OR SUPPLIER		701	ET ADDRESS, CITY, STATE, ZIP (HENRY ST RTH VERNON, IN47265		
	SUMMARY S' (EACH DEFICIEN REGULATORY OR by date. 6. The Dietary observed to the of mayonnaise pickle relish, been dated who Dietary Management were used that salad. 6. The gas coordinated observed to has grease over end of the ovens were used that salad. 7. A deep fat to be covered we spices. 7. A deep fat to be covered sticky/greasy in the order of the overed sticky/greasy in the order of the order of the overed sticky/greasy in the order of the order	Manager was row out a 1/4 full jar e and a 1/4 full jar of These jars had not en opened. The ger indicated they morning to make ok stove was eve a heavy layer of tire stove. The doors were sticky to touch. er the stove which herous jars of spices with grease and dried fryer was observed with a heavy layer of	701	HENRY ST RTH VERNON, IN47265 PROVIDER'S PLAN OF COL	RRECTION SHOULD BE	(X5) COMPLETION DATE
	cleaned "tonig					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155665		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/04/2011	
	ROVIDER OR SUPPLIER		701 H	CADDRESS, CITY, STATE, ZIP CODE ENRY ST TH VERNON, IN47265		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	covered with a sticky/greasy rand sticky/greasy rand sticky/greadoors. 9. The top of machine was or residue and crace residue was observed as a starting dipurage was observe	onfection oven was a heavy layer of residue down the side asy residue on the the dish washer covered with greasy numbs. Dried food oserved down in the dge of the machine. ides were observed of lunch. A soiled wed on the steam table anitation buckets had of Dietary Aide #6 to clean spills which by laundry. No kets were set up for liately after Dietary this comment, the ger instructed her to ith soapy water and				

PRINTED: 03/24/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155665	B. WIN			03/04/2	011
NAME OF F	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
JENNING	SS HEALTHCARE C	CENTER		1	I VERNON, IN47265		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	COMPLETION DATE
	use for wipe u	p of spills.					
		"Nutrition Services					
		Labeling Reference					
	•	ovided by the Dietary					
	_	2/28/11 at 12:30 p.m.					
	1	dicated, "When					
	food item is op						
		ed, write the open					
		od container. Write a					
	use by date on						
	containerMu						
		yonnaiseUse					
	within 2 month	hs after opening.					
	A policy titled	"Sanitation" was					
	provided by th	e Dietary Manager					
	on 02/28/11 at	12:30 p.m.					
	· ·	trition services staff					
	prepares food	in a manner that					
		ritive value, enhances					
		events food borne					
		and sanitize all work					
		oment, and utensils					
		sanitizer after each					
		ths or towels for					
		oills. Do not use the					
	same towels for	or other purposes.					

010996

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155665		A. BUILDING	E CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 03/04/2011			
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		NORTH VERNON, IN47265 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
	Keep a bucket with sanitizing change water of more often as and sanitizing tabletops -Cou are cleaned be preparationC a clean cloth s detergent water immediately determined.	full of warm water g solution available; every two hours or neededCleaning counters and tabletops fore and after food clean off debris using toaked in warm er. Wipe spills uring preparation.						

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
155665			B. WING 03/04/2011			011	
NAME OF F	DOMINED OD GUDDU IED	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				701 HE	NRY ST		
	SS HEALTHCARE (CENTER		NORTH	I VERNON, IN47265		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)			· · · · · · · · · · · · · · · · · · ·		DATE
F0514		review and interview, the	F05	14	It is the policy of this facility to comply with regulatory		04/03/2011
SS=D	=	maintain residents'			requirements regarding		
		hich were complete and			maintaining complete and		
	-	nented in that 1 resident			accurate records of the care		
		cumentation of a Foley			provided the residents.1.		
	•	(Resident #57) and 1			Resident #57's physician has been notified of the alledged lack		
	resident had inco	emplete documentation of			of clinical	ack	
	tracheostomy car	re. (Resident#23) This			documentation regarding		
	affected 2 of 18	residents reviewed for			the indwelling catheter change	e.	
	complete and accurate clinical record				Resident #23's physician has	.	
	documentation in a sample of 18.				been notified of the alledged la of clinical documentation	аск	
	Findings include:				regarding trach care for the		
					identified dates. There were n	o	
					negative outcomes to either		
	A policy and procedure for				residents regarding the lack of		
	"Documentation Guidelines" with a				documentation.2. All residents	6	
	revised date of 8/10, was provided by the				with trachs and indwelling catheters were QA for issues		
	administrator on 3/4/11 at 12:45 p.m. The				related to documentation of ca	are	
		_			provided. The physician's of the	nese	
	policy indicated, but was not limited to: "All entries into the medical record should				residents were notified of the		
	be legible, dated, timed, and written in ink. All documentation must include the staff member's legible signature and titleIneffective documentation practices include but are not limited toLeaving				deficit charting issues. There		
					were no negative outcomes for any resident whose records w		
					reviewed.3. Licened Nurses,		
					QMAs and CNAs were provide	ed	
					inservicing regarding the		
					professional standards for		
	blanks or spaces	in the medical record"			documentation of these areas the DON and Administrator or	· .	
					March 18, 2011. The DON or	'	
	1. Resident #57'	s record was reviewed on			designee will complete weekly	/ QA	
	3/3/2011 at 10:50	a.m. The record			of the TARs for 3 months to		
	indicated Reside	nt #57 was admitted with			ensure compliance to the		
	diagnoses that in	cluded, but were not			documentation of trach and	_{to}	
	_	iplegia and chronic			indwelling catheter according professional practice standard		
	anxiety.				4.The results of these audits v		
	,						

NAME OF PROVIDER OR SUPPLIER INTEREST AND STATEMENT OF DEFICIENCIES PREFIX TAG A physician's order dated 10:29/10 indicated an order for a Foley catheter to bedside drainage, 20 french (size of catheter) /30 ce (cubic centimeters) bulb, change every month. Documentation on the treatment flow sheets and nurses notes indicated the Foley catheter had been changed in February 2011. During an interview on 3/3/11 at 3:45 p.m. with LPN #9, indicated LPN #9 had changed the Foley catheter the head changed the Foley catheter the next day, LPN #9 indicated she would write a late entry in the resident's record, and that she had gotten a catheter out of central supplies the day she changed the catheter. 2. Resident #23's record was reviewed on 3/3/11 at 9:25 a.m. The record indicated Resident #23's as admitted with	STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAMINO PROVIDIR OR SUPPLIER JENNINGS HEALTHCARE CENTER (X4) ID SUMMARY STATEMINT OF DEPICENCES (BEACH DEFICENCY MUST BE PERCEDED BY PULL ADDRESS). A physician's order dated 10/29/10 indicated an order for a Foley catheter to bedside drainage, 20 french (size of catheter) /30 cc (cubic centimeters) bulb, change every month. Documentation on the treatment flow sheets and nurses notes indicated the Foley catheter had been changed in February 2011. During an interview on 3/3/11 at 3:45 p.m. with LPN #9, indicated LPN #9 had changed the Foley catheter for Resident #57 on 2/25/11. LPN #9 indicated she had changed the Foley catheter the day after re-writes" because she had helped with re-writes on 2/24/11, and had changed the Foley catheter the advanter rise because she had helped with re-writes" because she had helped with re-writes" because she had helped with re-writes on 2/24/11, and had changed the Foley catheter the advanter rise because she had helped with re-writes" because she had helped with re-writes" because she had helped with re-writes on 2/24/11, and had changed the Foley catheter the ext day. LPN #9 indicated she would write a late entry in the resident's record, and that she had gotten a catheter out of central supplies the day she changed the catheter. 2. Resident #23's record was reviewed on 3/3/11 at 9.25 a.m. The record indicated Resident #23 was admitted with	AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A RIHI DING			COMPLETED	
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG A physician's order dated 10/29/10 indicated an order for a Foley catheter to bedside drainage, 20 french (size of catheter) /30 cc (cubic centimeters) bulb, change every month. Documentation on the treatment flow sheets and nurses notes indicated the Foley catheter was changed in November 2010, December 2010, and January 2011, but no documentation was in the record that the Foley catheter had been changed in February 2011. During an interview on 3/3/11 at 3:45 p.m. with LPN #9 indicated LPN #9 had changed the Foley catheter "the day after re-writes" because she had helped with re-writes on 2/24/11, and had changed the Foley catheter the next day. LPN #9 indicated she would write a late entry in the resident's record, and that she had gotten a catheter out of central supplies the day she changed the catheter. 2. Resident #23's record was reviewed on 3/3/11 at 9:25 a.m. The record indicated Resident #23 was admitted with	155665					03/04/2011			
JENNINGS HEALTHCARE CENTER JENNINGS HEALTHCARE CENTER (CA) ID REGULATORY OR LSC IDENTIFYING INFORMATION) A physician's order dated 10/29/10 indicated an order for a Foley catheter to bedside drainage, 20 french (size of catheter) /30 ce (cubic centimeters) bulb, change every month. Documentation on the treatment flow sheets and nurses notes indicated the Foley catheter had been changed in February 2011. During an interview on 3/3/11 at 3:45 p.m. with LPN #9, indicated LPN #9 had changed the Foley catheter for Resident #57 on 2/25/11. LPN #9 indicated she had changed the Foley catheter the next day. LPN #9 indicated she would write a late entry in the resident's record, and that she had gotten a catheter out of central supplies the day she changed the catheter. 2. Resident #23's record was reviewed on 3/3/11 at 9:25 a.m. The record indicated Resident #23 was admitted with						ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
JENNINGS HEALTHCARE CENTER (X0.10) SUMMARY STATEMENT OF DEFICIENCIES GEACH DEFICIENCY MUST BE PERCEDDE BY PULL TAG A physician's order dated 10/29/10 indicated an order for a Foley catheter to bedside drainage, 20 french (size of catheter) /30 cc (cubic centimeters) bulb, change every month. Documentation on the treatment flow sheets and nurses notes indicated the Foley catheter was changed in November 2010, December 2010, and January 2011, but no documentation was in the record that the Foley catheter had been changed in February 2011. During an interview on 3/3/11 at 3:45 p.m. with LPN #9, indicated LPN #9 had changed the Foley catheter the nad changed the Foley catheter the nad changed the Foley catheter the next day. LPN #9 indicated she had changed the Foley catheter the next day. LPN #9 indicated she had gotten a catheter out of central supplies the day she changed the catheter. 2. Resident #23's record was reviewed on 3/3/11 at 9:25 a.m. The record indicated Resident #23's awa admitted with	NAME OF F	PROVIDER OR SUPPLIER							
REFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A physician's order dated 10/29/10 indicated an order for a Foley catheter to bedside drainage, 20 french (size of catheter) /30 cc (cubic centimeters) bulb, change every month. Documentation on the treatment flow sheets and nurses notes indicated the Foley catheter was changed in November 2010, December 2010, and January 2011, but no documentation was in the record that the Foley catheter had been changed in February 2011. During an interview on 3/3/11 at 3:45 p.m. with LPN #9, indicated LPN #9 had changed the Foley catheter 'The day after re-writes' because she had helped with re-writes on 2/24/11, and had changed the Foley catheter the next day. LPN #9 indicated she would write a late entry in the resident's record, and that she had gotten a catheter out of central supplies the day she changed the catheter. 2. Resident #23's record was reviewed on 3/3/11 at 9:25 a.m. The record indicated Resident #23 was admitted with	JENNING	GS HEALTHCARE (CENTER		1				
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diagnoses that included, but were not limited to, major depressive disorder,	TAG	A physician's ordindicated an order bedside drainage catheter) /30 cc (change every modes bedside drainage catheter) /30 cc (change every modes beds and nurses Foley catheter was 2010, December but no document that the Foley catheter was 2011. During an intervipum, with LPN # changed the Fole #57 on 2/25/11. had changed the after re-writes but with re-writes on changed the Fole LPN #9 indicated entry in the resid had gotten a cathes supplies the day and 2. Resident #23' 3/3/11 at 9:25 a.r. Resident #23 was diagnoses that in	der dated 10/29/10 er for a Foley catheter to , 20 french (size of cubic centimeters) bulb, onth. on the treatment flow s notes indicated the as changed in November 2010, and January 2011, ation was in the record theter had been changed . dew on 3/3/11 at 3:45 9, indicated LPN #9 had ey catheter for Resident LPN #9 indicated she Foley catheter "the day ecause she had helped a 2/24/11, and had ey catheter the next day. d she would write a late ent's record, and that she eter out of central she changed the catheter. s record was reviewed on m. The record indicated s admitted with cluded, but were not		TAG	be reorted to the facility QA Comittee by the DON no less than monthly for review and		DATE	

NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) stroke with hemorrhage, diabetes mellitus, STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN47265 (X7) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE APPROPR	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155665			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/04/2011		
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Stroke with hemorrhage, diabetes mellitus, PREFIX PREFIX PREFIX PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE DATE DATE TO STOKE WITH HEMORRHAGE DEFICIENCY DATE OF COMPL TO STOKE WITH HEMORRHAGE DEFICIENCY TO STOKE WITH HEMORRHAGE DEFICE DEFICIENCY TO STOKE WITH HEMORRHAGE DEFICIENCY				STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST				
stroke with hemorrhage, diabetes mellitus,	PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE	
congestive heart failure, high blood pressure, asthma, diabetic retinopathy, chronic respiratory failure with tracheostomy, and gastrostomy tube. Physician's orders dated 1/19/11 included an order for tracheostomy care every shift. Treatment administration records (TARS) dated 1/2011 indicated the following times no initials were signed that would indicate the tracheostomy care had been done: 1/20 on the 7-3 shift and 1/21, 1/22 on the 3-11 shift. TARS dated 2/2011 indicated the following dates and shifts tracheostomy care was either not initialed as done or the initials had been circled to indicate the treatment was not done: - 2/16 on the 11 - 7 shift - no initials - 2/18 on the 7 - 3 shift and 11 - 7 shift- no initials - 2/19 on the 11 - 7 shift, initials were circled with no explanation - 2/20 on the 7 - 3 shift, initials were circled with no explanation - 2/21, 2/22, and 2/23 on the 7 - 3 shift, no initials - 2/24 on the 11 - 7 shift, initials were circled with no explanation - 2/26 on the 7 - 3 shift, initials were circled with no explanation - 2/26 on the 7 - 3 shift, initials were circled with no explanation - 2/26 on the 7 - 3 shift, initials were circled with no explanation	IAG	stroke with hemore congestive heart pressure, asthmat chronic respirator tracheostomy, and Physician's order an order for track. Treatment admined ated 1/2011 indicated the track done: 1/20 on the on the 3-11 shift. TARS dated 2/20 following dates a care was either minitials had been treatment was not a care with the entreatment was not a care with the entreatment of th	orrhage, diabetes mellitus, failure, high blood and diabetic retinopathy, ory failure with and gastrostomy tube. Its dated 1/19/11 included theostomy care every shift. Inistration records (TARS) dicated the following were signed that would theostomy care had been the 7-3 shift and 1/21, 1/22. In the structure of the structure of the circled to indicate the circled to indicate the cot done: In the structure of the circled to indicate the cot done: In the structure of the structure of the circled to indicate the cot done: In the structure of the structure of the circled to indicate the cot done: In the structure of the str	IAG	DEPICIENCY)		DATE	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155665		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/04/2011			
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN47265					
	SUMMARY S' (EACH DEFICIEN REGULATORY OR the 11 - 7 shift, i no explanation - 2/27 on the 7 - the 11 - 7 shift, i no explanation During an interv p.m., the Directo blanks on the tre record meant the if the initials wer wasn't done or th said the nurses sl of the TAR the r		701 HE	NRY ST	E TION LD BE	(X5) COMPLETION DATE		